

# Harrison Board of Education Flexible Spending Account Compensation Reduction Agreement

for the Plan Year beginning July 1, 2011 and ending June 30, 2012

Employer Use Only	
Group No.	_____
Corrected	_____
Change of Status	_____
Effective Date	_____
Termination Date	_____
Division	_____
Date of Hire	_____

Last Name	First Name	M.I.	Identification Number/ SS#		
Home Address	Street	City	State	Zip	Date of Birth / /
E-mail Address					
List Dependents by Last Name, First Name, M.I.		Relationship	Identification/SS#	Date of Birth MM/DD/YY	

I hereby make the following election(s) or waiver(s) regarding the benefits made available to me under my employer's Flexible Spending Account and acknowledge my understanding that:

- > I elect to reduce my annual, taxable compensation by an amount equal to the total value of the benefits specified below;
- > the annual amount will be deducted in approximately equal sums from my regular paychecks during the coming Plan Year;
- > this election will remain in effect until the last day of the Plan Year during which I am a participant;
- > my election may be changed only upon the occurrence of a Change in Family Status as described in the Plan Document;
- > by taking less taxable pay, my Social Security benefits could be reduced;

> this form must be completed and returned to the Harrison Board of Education, 517 Hamilton Street, Harrison, NJ 07029 no later than Friday, June 17, 2011.

## Premium Conversion Plan

- Medical/ Prescription Drug  
 Dental/Vision
- 1.5% of Base Pay  
 per Pay Period
- waive participation

> I have been given the opportunity to participate in the Flexible Spending Account and have indicated my election(s) or waiver(s) above. I acknowledge that I am not eligible to change my participation until the next enrollment period, or if earlier, the occurrence of a Change in Family Status.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_ Evening Phone Number \_\_\_\_\_